FOR COUNTY USE ONLY

County of San Bernardino

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STANDARD CONTRACT

[X] New / [ ] Change / [ ] Cancel	Vendor Code: REDLAND347	SC	Dept. A		Contract Number
County Department: Behavioral Health		Dept.: MLH	Orgn.: MLH		Contractor's License No.
County Department Contract Representative: Doug Moore		Telephone: 387-7589			Total Contract Amount: $99,225
Contract Type: [ ] Revenue [X] Encumbered [ ] Unencumbered [ ] Other:					
If not encumbered or revenue contract type, provide reason:					
Commodity Code		Contract Start Date: July 1, 2003	Contract End Date: June 30, 2006	Original Amount: $99,225	Amendment Amount

Fund	Dept.	Organization	Appr.	Obj/Rev Source	GRC/PROJ/JOB No.	Amount
AAA	MLH	MLH	200	2445		$99.225

Project Name: Negotiated Rate FFS Acute Psychiatric Inpatient Services Contract Type – 2(b)

Estimated Payment Total by Fiscal Year

FY	Amount	I/D	FY	Amount	I/D
03/04	$33,075				
04/05	$33,075				
05/06	$33,075				

THIS CONTRACT is entered into in the State of California by and between the County of San Bernardino, hereinafter called the County, and

Name: Redlands Community Hospital — hereinafter called: Contractor

Address: 350 Terracina Boulevard

Redlands, CA 92373

Telephone: (909) 335-5500 — Federal ID No. or Social Security No.: 95-16743347

IT IS HEREBY AGREED AS FOLLOWS*:*

(Use space below and additional bond sheets. Set forth service to be rendered, amount to be paid, manner of payment, time for performance or completion, determination of satisfactory performance and cause for termination, other terms and conditions, and attach plans, specifications, and addenda, if any.)

WITNESSETH

WHEREAS, County has submitted the San Bernardino County Mental Health Plan (MHP) to the State of California to participate in Medi-Cal Mental Health Managed Care to provide a comprehensive and balanced range of mental health services; and

WHEREAS, County has determined that there is a need for psychiatric inpatient hospital services for residents who, due to mental illness, are a danger to self, others or gravely disabled; and

WHEREAS, Contractor hereby recognizes that this Contract is formed under the authority of the Welfare and Institutions (W & I) Code and the regulations adopted pursuant thereto, which authorize the County to contract for provision of psychiatric inpatient hospital services to beneficiaries eligible for such services under the Medi-Cal program in accordance with the rates, terms and conditions negotiated by the County:

NOW, THEREFORE, the parties hereto do mutually agree to terms and conditions as follows:

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I Definition of Terminology

A. Wherever in this document, and attachments hereto, the terms "Contract" and/or "Agreement" are used to describe the conditions and covenants incumbent upon the parties hereto, these terms are interchangeable.

B. Definition of May, Shall and Should. Whenever in this document the words "may", "shall" and "should" have been used, the following definitions apply: "may" is permissive; "shall" is mandatory; and "should" means desirable.

C. The following definitions pertaining to Medi-Cal Psychiatric Inpatient Hospital Services are applicable hereunder:

1. Administrative Day Services is defined in Title 9, California Code of Regulations (CCR) Section 1701 as " Services authorized by a Mental Health Plan's Point of Authorization or a Short-Doyle /Medi-Cal provider's Utilization Review Committee that is acting as a Point of Authorization, for a beneficiary residing in a psychiatric inpatient hospital when, due to a lack of residential placement options at appropriate, non-acute treatment facilities as identified by the Mental Health Plan, the beneficiary's stay at the psychiatric inpatient hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services." During the hospital stay, the beneficiary must also have met the medical necessity criteria for acute psychiatric inpatient hospital services.

   The San Bernardino County Mental Health Plan has identified the following as Medi-Cal eligible non-acute treatment facilities that meet the Administrative Day Service criteria:

   a) State Hospital;
   b) Skilled Nursing facilities with a psychiatric component;
   d) Institute for Mental Disease;
   e) Licensed augmented board and care. These are designated board and care facilities that have a contract with DBH to provide specialized enhanced services to targeted populations. Non-augmented licensed board and care facilities do not qualify for administrative day reimbursement;

f) Shandin Hills Adolescent Center (SHAC);

g) RCL level 14-9 (Dept. of Behavioral Health Children's Residential System of Care (CRSOC) case manager should be involved to determine that the level of placement is clinically appropriate.)

2. Ancillary services: Use of hospital facilities; laboratory, medical and social services furnished by the hospital; drugs such as take home drugs, biologicals, supplies, appliances and equipment; nursing, pharmacy and dietary services; and administrative services required to provide such services.

3. Beneficiary: Any person certified as eligible for services under the Medi-Cal Program according to Title 22, California Code of Regulations.

4. Border community: Out of State community with providers that frequently serve Medi-Cal beneficiaries from California - i.e., Reno, Klamath Falls, Medford, Yuma.

5. Complaint Resolution Process: An informal process at the county or provider level whereby beneficiary complaints and concerns regarding mental health services are addressed by easily understood processes with the intent of resolving as many disputes as possible at this level.

6. Consolidation: Transfer of Fee-for-Service/Medi-Cal psychiatric inpatient hospital services to create a single entity responsible for funding and authorization for medically necessary psychiatric inpatient hospital services for Medi-Cal beneficiaries.

7. Emergency psychiatric condition: A condition that exists when a Medi-Cal beneficiary requires voluntary or involuntary hospitalization because he/she meets the criteria for medical necessity for psychiatric inpatient hospital services and presents, as a result of a mental disorder; as:

   a. A danger to self, or
   b. A danger to others, or
   c. Immediately unable to provide for or utilize food, shelter or clothing.

8. Fee-for-Service/Medi-Cal: California's Medicaid program that provides reimbursement for a broad array of health and limited mental health services to eligible individuals.

9. Fiscal intermediary: That person who or entity which has contracted, as specified in W & I Code, to perform fiscal intermediary services for Fee-for-Service/Medi-Cal providers.

10. Grievance process: A written beneficiary statement that initiates a dispute resolution process at the county level, which requires a written county response.

11. Licensed mental health professionals: Includes physicians, psychologists, licensed clinical social workers, marriage and family therapists, registered nurses, licensed vocational nurses, and psychiatric technicians.

12. Medical necessity criteria: The principal criteria by which a mental health plan will determine authorization for payment for acute psychiatric inpatient hospital services.

13. Mental health plan: An entity, which enters into an agreement with the State to provide Medi-Cal beneficiaries from a specific county with psychiatric inpatient hospital services. The plan may be a county, counties acting jointly, or other governmental or nongovernmental entity.

14. Non-contract facility: A provider of psychiatric inpatient hospital services with which a mental health plan has not contracted.

15. Prior authorization: Requirement for written approval for payment before services are rendered.

16. Psychiatric inpatient hospital services: Services provided either in an acute care hospital or a freestanding psychiatric hospital for the care and treatment of an acute episode of mental illness. Services provided in a freestanding hospital may only be reimbursed by Medi-Cal for persons age 20 or younger and 65 or older.

17. Quality Management Plan: A document that establishes procedures for the objective and systematic monitoring and evaluation of the quality and appropriateness of services to Medi-Cal beneficiaries. It also identifies ways to solve system problems and improve services.

18. Traditional hospital provider: A provider that, according to the latest historical payment data, provides services to residents of a county that account for five percent or $20,000.00 (whichever is more) of the total fiscal year Fee-for-Service/Medi-Cal psychiatric inpatient hospital service payments made for beneficiaries of the county.

II Contract Supervision

The Director of the County of San Bernardino, Department of Behavioral Health (DBH), (hereinafter referred to as Director, or designee), shall be the County employee authorized to represent the interests of the County in carrying out the terms and conditions of this Contract. The Contractor shall provide, in writing, the names of persons who are authorized to represent the Contractor in this Agreement.

III Performance

A. Contractor shall provide acute psychiatric inpatient hospital services under this Agreement, which are further described in the attached Addendum I.

B. Contractor agrees to render psychiatric inpatient hospital services to eligible beneficiaries in need of such services and assumes full responsibility for provision of all psychiatric inpatient hospital services in accordance with regulations adopted pursuant to the W&I Code and as provided in this Contract. Contractor agrees to accept, as payment in full for any and all psychiatric inpatient hospital services, payments made pursuant to Article V Payment of this Contract. The County agrees to pay the Contractor for such services rendered in accordance with the terms, and under the express conditions of, this Contract.

C. Contractor agrees to render psychiatric inpatient hospital services to Medically Indigent Adults and/or Children in need of such services up to a maximum of Sixty Three (63) days per year and assumes full responsibility for provision of all psychiatric inpatient hospital services in accordance with the W&I Code and

regulations adopted pursuant thereto W&I Code and as provided in this Contract. Contractor agrees to accept, as payment in full for any and all psychiatric inpatient hospital services, payments made pursuant to Article V Payment, Paragraph A., 3 of this Contract. The County agrees to pay the Contractor for such services rendered in accordance with the terms, and under the express conditions of, this Contract.

D. Contractor shall, at its own expense, provide and maintain facilities and professional, allied and supportive paramedical personnel to provide all necessary and appropriate psychiatric inpatient hospital services.

E. Contractor shall, at its own expense, provide and maintain the organizational and administrative capabilities to carry out its duties and responsibilities under this Contract and all applicable statutes and regulations pertaining to Medi-Cal providers.

G. If, for any reason, information in Addendum I conflicts with the basic Agreement, information in Addendum I shall take precedence.

IV Funding

A. The maximum financial obligation of County is limited by the available State and County funds for this agreement. The maximum financial obligation of the County under this agreement shall not exceed the sum of Ninety Nine Thousand Two Hundred Twenty Five Dollars ($99,225.00), which represents the maximum Net County funding allocation to Contractor for indigent services for the period of July 1, 2003 through June 30, 2006.

1. The maximum financial obligation of the County under this agreement for the period of July 1, 2003 through June 30, 2004 shall not exceed the sum of Thirty Three Thousand Seventy Five Dollars ($33,075.00) for inpatient Indigent care.

2. The maximum financial obligation of the County under this agreement for the period of July 1, 2004 through June 30, 2005 shall not exceed the sum of Thirty Three Thousand Seventy Five Dollars ($33,075.00) for inpatient Indigent care.

3. The maximum financial obligation of the County under this agreement for the period of July 1, 2005 through June 30, 2006 shall not exceed the sum of Thirty Three Thousand Seventy Five Dollars ($33,075.00) for inpatient Indigent care.

B. Contractor agrees to accept a reduction of the dollar value of this contract, at the option of the County, if the annualized projected days of services based on claims submitted through February each fiscal year is less than 90% of the projected annualized days of services as reported on monthly claims or as revised and approved by the Director.

C. If the annualized projected days of services based on claims submitted through February each fiscal year is greater than/or equal to 110% of the projected annualized days of services, or as revised and approved by the Director, the County and Contractor agree to meet and discuss the possibility of renegotiating this agreement to accommodate the additional annualized services expected to be provided through the end of each fiscal year.

D. If the Federal Government reduces its allocation of federal funding coming to the State Medi-Cal program, the County agrees to meet with Contractor to discuss the possibility of renegotiating the services required by this agreement.

V Payment

A. Provided that there shall first have been a submission of claims in accordance with Article V Paragraph F., the Contractor shall be paid at the following all-inclusive rate per patient day for acute psychiatric inpatient hospital services, less any third party coverage as described in Article V Paragraph D.:

1. Medi-Cal Acute Psychiatric Inpatient Day: Reimbursement for Acute Psychiatric Inpatient Services shall be $525.00 per day.

2. Medi-Cal Administrative Day: Per State Department of Mental Health (DMH) Notice 01-03, dated 5/29/01, the Administrative Day rate is established by DMH in accordance with the regulations and is not established by the Counties.

3. Indigent Care Reimbursement: The Department of Behavioral Health will reimburse contract hospitals at a rate of $525.00 per day for treatment of Medically Indigent Adults and/or Children who are brought to the Contractor's facility by a 5150 application written by law enforcement or a DBH 5150-designated staff when said patient is brought to the facility as a direct result of Arrowhead Regional Medical Center Behavioral Health Inpatient Unit (ARMC-BH) being on diversionary status. Eligibility for Indigent Care Reimbursement will be contingent upon San Bernardino County residency and substantiation of ineligibility for other coverage or proof of denied Medi-Cal benefits. Procedures for Indigent Care Reimbursement are detailed in Attachment II, DBH REIMBURSEMENT REQUIREMENTS.

B. The rate structure under Article V Paragraph A. of this Contract is intended by both the County and the Contractor to be inclusive of all services of this Contract.

C. The rate structure under Article V Paragraph A. of this Contract shall not include physician services nor non-hospital based ancillary services rendered to beneficiaries covered under this Contract, or transportation services required in providing Psychiatric Inpatient Hospital Services. When physician and non-hospital based ancillary services or transportation services are Medi-Cal eligible services, they shall be billed separately from the per diem rate for Psychiatric Inpatient Hospital Services.

D. As an express condition precedent to the County's payment obligation under Article V Paragraph A. of this Contract, the Contractor shall determine that psychiatric inpatient hospital services rendered hereunder are not covered, in whole or in part, under any other state or federal medical care program or under any other contractual or legal entitlement, including, but not limited to, a private group indemnification or insurance program or worker's compensation. To the extent that such coverage is available, the County's payment obligation pursuant to Article V Paragraph A. shall be reduced.

E. Contractor shall submit Treatment Authorization Requests (TARs) to County for all Medi-Cal eligible clients and Medically Indigent Adult and/or Children in accordance with the procedures that are further described in the attached addenda. The completed TARs that authorize medically necessary psychiatric inpatient days will provide the basis for reimbursement to Contractor.

F. Contractor shall submit claims to the fiscal intermediary [Electronic Data Systems (EDS)], and shall submit indigent claims to DBH directly for all services rendered under the terms of this Contract, in accordance with the applicable billing requirements contained in the W&I Code and the regulations adopted pursuant thereto. EDS shall make payment to Contractor in accordance with the rates set out in Article V Paragraph A.

G. The Contractor shall bear total risk for the cost of all psychiatric inpatient hospital services rendered to each beneficiary covered by this Contract. As used in this Article, "risk" means that the Contractor agrees to accept, as payment in full for any and all psychiatric inpatient hospital services, payments made pursuant to Article V of this Contract. Such acceptance shall be made irrespective of whether the cost of such services and related administrative expenses shall have exceeded the payment obligation of the County under the conditions set forth in this Contract. The term "risk" also includes, but is not limited to, the cost for all psychiatric inpatient hospital services for illness or injury which results from or is contributed to by catastrophe or disaster which occurs subsequent to the effective date of this Contract, including but not limited to acts of God, war or the public enemy.

VI Special Reports

Contractor agrees to submit fiscal and statistical reports as required by the DBH Director, which are further described throughout the attached Addendum I.

VII Audit of Services

A. Contractor agrees to maintain and retain all appropriate service and financial records for a period of at least five years, or until audit findings are resolved, which ever is later. This is not to be construed to relieve Contractor of the obligations concerning retention of medical records as set forth in Article XVII Medical Records, Paragraphs A. and B.

B. Contractor agrees to furnish duly authorized representatives from County and State access to patient records and to disclose to State and County representatives all financial records necessary to review or audit contract services and to evaluate the cost, quality, appropriateness and timeliness of services. Said County or State

representative shall provide a signed copy of a confidentiality statement similar to that provided for in Section 5328(e) of the W & I Code, when requesting access to any patient records. Contractor will retain said statement for its records.

C. If a post contract service audit finds that units of service and/or other activity of Contractor paid for hereunder were not performed in accordance with this Agreement, the Contractor shall reimburse the County on demand therefore at the negotiated rates in Article V Payment, Paragraph A. Reimbursement shall be made by Contractor to County using one of the following methods, which shall be at the election of the County:

1. Payment of total.

2. Payment on a monthly schedule of reimbursement.

3. Credit on future billings.

D. Contractor agrees to cooperate with County in the implementation, monitoring and evaluation of inpatient mental health services and to comply with any and all reporting requirements established by County, the State of California and any and all Federal agencies providing monies for the services described herein.

VIII Duration and Termination

A. The term of this Agreement shall be from July 1, 2003 through June 30, 2006, inclusive.

B. This Agreement may be terminated immediately by the Director at any time if:

1. The appropriate office of the State of California indicates that this Agreement is not subject to reimbursement under law; or

2. There are insufficient funds available to County because the State has failed to transfer State General Fund Fee-for-Service Medi-Cal match to the County; or

3. The State or Director determines that the Contractor is abusing or defrauding, or has abused or defrauded, the Medi-Cal program or its beneficiaries; or

4. The Contractor is found not to be in compliance with any or all of the terms of the following Articles of this Agreement: X Personnel, XI Licensing and Certification, or XX Indemnification and Insurance.

C. Either the Contractor or Director may terminate this Agreement at any time for any reason, or no reason by serving 30 days written notice upon the other party.

D. This Agreement may be terminated at any time without 30 days notice by the mutual written concurrence of both Contractor and the DBH Director.

E. If Contractor anticipates ceasing operation of its facility for any reason, County is to be notified by Contractor in writing immediately upon such anticipation, or no less than 24 hours prior to cessation. Arrangements are to be made by Contractor with County approval for preservation of the program activity and financial records.

IX Patient/Client Billing

A. Contractor agrees to collect any third party coverage and/or share of costs for eligible patients.

B. The State of California "Uniform Method of Determining Ability to Pay" (UMDAP) shall be followed in charging clients for services under this agreement.

C. The State of California " Uniform Billing and Collection Guidelines" shall be followed in the billing and collecting of patient fees.

X Personnel

A. Contractor shall operate continuously throughout the term of this Agreement with at least the minimum number of staff as required by law to perform its duties and obligations hereunder.

B. Contractor shall make available to County, on request, a list of the persons who shall provide services under this Agreement. Said list shall include name, title, professional degree and job description.

C. Contractor agrees to provide or has already provided information on former County of San Bernardino administrative officials (as defined below) who are employed by or represent Contractor. The information provided includes a list of former County administrative officials who terminated County employment within the last five years and who are now officers, principals, partners, associates or members of the business. The information also includes the employment with or representation of Contractor. For purposes of this provision, "County administrative official" is defined as a member of the Board of Supervisors or such officer's staff, County Administrative Officer or member of such officer's staff, County department or group head, assistant department or group head, or any employee in the Exempt Group, Management Unit or Safety Management Unit. If during the course of the administration of this agreement, the County determines that the Contractor has made a material misstatement or misrepresentation or that materially inaccurate information has been provided to the County, this contract may be immediately terminated. If this contract is terminated according to this provision, the County is entitled to pursue any available legal remedies.

XI Licensing and Certification

A. Contractor hereby represents and warrants that it is currently, and for the duration of this Contract shall remain, licensed as a general acute care hospital or acute psychiatric hospital in accordance with Section 1250 et seq. of the Health and Safety Code and the licensing regulations contained in Title 22 and Title 17 of the California Code of Regulations.

B. Contractor hereby represents and warrants that it is currently, and for the duration of this Contract shall remain, certified under Title XVIII of the Federal Social Security Act.

XII Administrative Procedures

Contractor agrees to adhere to all applicable provisions contained in the San Bernardino County Local Managed Mental Health Care Plan and the Medi-Cal Psychiatric Inpatient

Hospital Services Emergency Regulations which are included as a part of this Contract by this reference.

XIII Laws and Regulations

A. Contractor agrees to comply with all applicable provisions of:

1. California Code of Regulations, Title 9

2. California Code of Regulations, Title 22

3. W&I Code

4. Titles 42 and 45 (Part 74) of the Code of Federal Regulations and all other applicable federal laws and regulations except for those provisions waived by the Secretary of Health and Human Services.

B. The Contractor stipulates that this Contract, in part, implements Title XIX of the Federal Social Security Act and, accordingly, agrees that it will conform to such requirements and regulations as the United States Department of Health and Human Services may issue from time to time, except for those provisions waived by the Secretary of Health and Human Services.

C. Pursuant to the Health Insurance Portability And Accountability Act of 1996 (HIPAA), regulations have been promulgated governing the privacy of individually identifiable health information. CONTRACTOR is a covered entity in accordance with HIPAA regulations (45 CFR § 160.103). Accordingly, CONTRACTOR is mandated to comply with the HIPAA Privacy Rule standards, requirements, and implementation specifications codified in 45 CFR Parts 160 and 164. CONTRACTOR will disclose Protected Health Information to appropriate County of San Bernardino personnel for the purposes of treatment, payment, and health care operations in accordance with 45 CFR § 164.506.

XIV Patients' Rights

Contractor shall adopt and post in a conspicuous place a written policy on patients' rights in accordance with Title 22 of the California Code of Regulations and with the W&I Code.

Complaints by beneficiaries with regard to substandard conditions may be investigated by the County's Patients' Rights Advocate, County, State Department of Mental Health or by the Joint Commission on Accreditation of Healthcare Organization, or such other agency, as required by law or regulation.

XV Confidentiality

Contractor agrees to comply with confidentiality requirements contained in the W&I Code, commencing with Section 5328, as well as any applicable requirements of 42 Code of Federal Regulations, Part 2.

XVI Admission Policies

Contractor shall admit and discharge clients in accordance with policies and procedures that are described in the applicable attached Addendum and Attachments.

XVII Medical Records

A. Contractor agrees to maintain and retain medical records according to the following:

The minimum legal requirement for the retention of medical records is:

1. For adults and emancipated minors, seven years following discharge (last date of service);

2. For unemancipated minors, at least one year after they have attained the age of 18, but in no event less than seven years following discharge (last date of service).

B. Contractor shall ensure that all patient/client records comply with any additional applicable State and Federal requirements.

XVIII Quality Assurance

Contractor agrees to adhere to the County's State-approved Implementation Plan for Psychiatric Inpatient Hospital Services Consolidation (also known as County Quality Management Plan), including State Department of Mental Health Letters and Notices, as

well as the W & I Code and regulations adopted pursuant thereto. The Contractor must also have an effective Quality Management/Utilization Review Plan to ensure quality of treatment services.

XIX Independent Contractor Status

Contractor understands and agrees that the services performed hereunder by its officers, agents, employees, or contracting persons or entities are performed in an independent capacity and not in the capacity of officers, agents or employees of the County. All personnel, supplies, equipment, furniture, quarters, and operating expenses of any kind required for the performance of this contract shall be the sole responsibility of contractor, which shall bear all costs relative thereto.

XX Indemnification and Insurance

A. Indemnification - The Contractor agrees to indemnify, defend and hold harmless the County and its authorized offices, employees, agents and volunteers from any and all claims, actions, losses, damages and/or liability for injury to persons and damage to property arising from Contractor's negligent acts, errors or omissions and for any costs or expenses incurred by the County on account of any claim therefore, except where such indemnification is prohibited by law. The County agrees to give the Contractor notice in writing within thirty (30) days of the claim made against it on the obligations covered hereby.

B. Insurance – Without in anyway affecting the indemnity herein provided and in addition thereto the Contractor shall secure and maintain throughout the contract the following types of insurance or self insurance with limits as shown:

1. Workers' Compensation – A program of Workers' Compensation Insurance or a State approved Self-Insurance Program in an amount or form to meet all applicable requirements of the Labor Code of the State of California, including Employer's Liability with $250,000 limits, covering all persons providing services on behalf of the Contractor and all risks to such persons under this Agreement.

2. Comprehensive General and Automobile Liability Insurance or Self Insurance – This coverage to include contractual coverage and automobile liability coverage for owned, hired and non-owned vehicles. The policy shall have combined single limits for bodily injury and property damage of not less than one million dollars ($1,000,000).

3. Errors and Omission Liability Insurance – Combined single limits of $1,000,000 for bodily injury and property damage and $3,000,000 in the aggregate or

4. Professional Liability – Professional liability insurance or self insurance with limits of at least $1,000,000 per claim or occurrence and $3,000,000 in the aggregate.

C. Additional Named Insured - All policies, except for the Workers' Compensation, Errors and Omissions and Professional Liability policies shall contain additional endorsements naming the County and its employees, agents, volunteers and officers as additional named insureds with respect to liabilities arising out of the performance of services hereunder.

D. Waiver of Subrogation Rights – Except for Errors and Omission Liability and Professional Liability, Contractor shall waive and shall require the carriers of the above required coverages to waive all rights of subrogation against the County, its officers, employees, agents, volunteers, contractors and subcontractors, except for negligent acts of the County of San Bernardino. This waiver of subrogation shall in no way affect any rights of indemnity either party may have as set forth above as such indemnity may apply to third party liability claims.

E. Policies Primary and Non-Contributory – All policies required above are to be primary and non-contributory with any insurance or self-insurance programs carried or administered by the County.

F. Proof of Coverage – Contractor shall immediately furnish certificates of insurance or self-insurance to the County evidencing the insurance coverage, including endorsements, above required prior to the commencement of performance of services hereunder, which certificates shall provide that such insurance shall not be terminated or expire without thirty (30) days written notice to the County and

Contractor shall maintain such insurance or self insurance from the time Contractor commences performance of services hereunder until the completion of such services. Contractor shall make available for inspection or review by the County or its authorized representatives certified copies of all insurance policies and trust documents upon which Contractor relies in providing the required coverage upon demand.

G. Insurance Review – The above insurance requirements are subject to periodic review by the County. The County's Risk Manager is authorized, but not required, to reduce or waive any of the above insurance requirements whenever the Risk Manager determines that any of the above insurance is not available, is unreasonably priced, or is not needed to protect the interests of the County. In addition, if the Risk Manager determines that heretofore unreasonably priced or unavailable types of insurance coverage or coverage limits become reasonably priced or available, the Risk Manager is authorized, but not required to change the above insurance requirements to require additional types of insurance coverage or higher coverage limits, provided that any such change is reasonable in light of past claims against the County, inflation, or any other item reasonably related to the County's risk.

Any such reduction or waiver for the entire term of the Agreement and any change requiring additional types of insurance coverage or higher coverage limits must be made by amendment to this Agreement. Contractor agrees to execute any such amendment within thirty (30) days of receipt.

H. The County hereby agrees to indemnify and hold harmless the Contractor from any and all liability claims, actions, losses, damages and/or liability for injury to persons and damage to property arising from County's negligent acts, errors or omissions and for any costs or expenses incurred by the Contractor on account of any claim therefore, except where such indemnification is prohibited by law. The Contractor agrees to give the County notice in writing within thirty (30) days of any claim made against the Contractor regarding the obligations covered hereby.

XXI Nondiscrimination

A. General. Contractor agrees to serve all patients without regard to race, color, sex, religion, national origin, or ancestry pursuant to the Civil Rights Act of 1964, as

amended (42 USCA, Section 2000 D), and Executive Order No. 11246, September 24, 1965, as amended.

B. Handicapped. Contractor agrees to comply with the Americans with Disabilities Act of 1990 (42 U.S.C. 1202 et seq.) which prohibits discrimination on the basis of disability, as well as all applicable Federal and State laws and regulations, guidelines and interpretations issued pursuant thereto.

C. Contractor agrees to and shall comply with the County's Equal Employment Opportunity Program and Civil Rights Compliance requirements:

1. Equal Employment Opportunity Program: The Contractor agrees to comply with the provisions of the Equal Employment Opportunity Program of the County of San Bernardino and rules and regulations adopted pursuant thereto: Executive Order 11246, as amended by Executive Order 11375, 11625, 12138, 12432, 12250, Title VII of the Civil Rights Act of 1964 (and Division 21 of the California Department of Social Services Manual of Polices and Procedures and California Welfare and Institutions Code, Section 10000), the California Fair Employment and Housing Act, and other applicable Federal, State, and County laws, regulations and policies relating to equal employment or social services to welfare recipients, including laws and regulations hereafter enacted.

   The Contractor shall not unlawfully discriminate against any employee, applicant for employment, or service recipient on the basis of race, color, national origin or ancestry, religion, sex, marital status, age, political affiliation or disability. Information on the above rules and regulations may be obtained from County DBH Contracts Unit.

2. Civil Rights Compliance: The Contractor shall develop and maintain internal policies and procedures to assure compliance with each factor outlined by state regulation. These policies must be developed into a Civil Rights Plan.

XXII Assignment

A. This Agreement shall not be assigned by Contractor, either in whole or in part, without the prior written consent of the Director.

B. This Contract and all terms, conditions and covenants hereto shall inure to the benefit of, and be binding upon, the successors and assigns of the parties hereto.

XXIII Conclusion

A. This Agreement consisting of twenty-one (21) pages, Addendum I, Attachments I, II, III, IV, V, and VI inclusive, is the full and complete document describing the services to be rendered by Contractor to County, including all covenants, conditions and benefits.

B. This agreement supersedes any and all agreements that may exist between the Contractor and the County.

C. IN WITNESS WHEREOF, the Board of Supervisors of the County of San Bernardino has caused this Agreement to be subscribed by the Clerk thereof, and Contractor has caused this Agreement to be subscribed on its behalf by its duly authorized officers, the day, month, and year first above written.

COUNTY OF SAN BERNARDINO

► _____
Dennis Hansberger, Chairman, Board of Supervisors

Dated: _____

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD
Clerk of the Board of Supervisors
of the County of San Bernardino.

By _____
Deputy

_____
(Print or type name of corporation, company, contractor, etc.)

By ► _____
(Authorized signature - sign in blue ink)

Name _____
(*Print or type name of person signing contract)*

Title _____
(Print or Type)

Dated: _____

Address _____

_____

Approved as to Legal Form	Reviewed by Contract Compliance	Presented to BOS for Signature
► _____	► _____	► _____
County Counsel		Department Head
Date _____	Date _____	Date _____

Auditor/Controller-Recorder Use Only

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COUNTY OF SAN BERNARDINO

I. Program Description

Historically, public mental health services in California have been reimbursed under two separate systems: Short-Doyle/Medi-Cal (county operated services) and Fee-for-Service Medi-Cal (private hospitals and practitioners). On January 1, 1995, these two systems were consolidated into a single, integrated service delivery system for psychiatric inpatient services. This single system is administered through the County of San Bernardino, Department of Behavioral Health (DBH), which acts as the Local Managed Mental Health Care Plan Agency (MHP). DBH/MHP has the responsibility for administering the Plan and managing the funds allocated by the State for all Medi-Cal acute inpatient psychiatric services within the County. MHP authorizes all Medi-Cal reimbursement for psychiatric inpatient services based on medical necessity. MHP also serves as a resource to private psychiatric hospitals, providing consultation on residential care and community support services.

II. Admission Criteria:

A. Pre-entry

Patients must be medically cleared prior to being admitted. All patients admitted to an acute care psychiatric facility are assumed to be medically clear.

B. Medi-Cal Eligibility and County of Residence Determination

1. Contractor is required to determine the Medi-Cal status of all patients being admitted to its facility. Contractor staff are to make a diligent effort to determine a patient's Medi-Cal status using a Point of Service device (POS) and/or by contacting the closest Social Security Office and/or by contacting the Medi-Cal office at 909/881-8306. If staff still have problems properly identifying a patient's Medi-Cal status, they are to contact the County DBH Financial Evaluation Section at 909/421-9412 for consultation. All efforts to determine Medi-Cal eligibility are to be well documented in patient charts. Contractor will only be able to bill a patient's Medi-Cal county of residence for services. No reimbursement will be given to a Contractor by a county for a Medi-Cal patient from another county, and in no event will any reimbursement be given unless the 24-hour notification, and 14-day post discharge Treatment

Authorization Request (TAR) requirements are met as described in Section II. F. of this Addendum.

2. Pending Eligibility/Retroactive Eligibility

In all cases where Medi-Cal is granted retro-actively, the Contractor is to submit the TAR after Medi-Cal has been granted, indicating on the TAR that Medi-Cal was granted retroactively. The 24-hour notification requirement of Paragraph II, B. 1. above shall be provided by Contractor in these cases.

3. Other Insurance

In all cases where there are other primary and secondary insurances, including Medicare, these sources are to be billed prior to Medi-Cal billing. In addition, in all cases where other insurance has been billed prior to Medi-Cal billing, and the Contractor expects to collect Medi-Cal reimbursement, should primary/secondary insurance be found to be exhausted, or the client otherwise be ineligible for receipt of benefits, the Contractor must have met 24-hour notification and 14-day post discharge TAR submission requirements as described in Section II. F. of this Addendum.

4. Uncertain County of Beneficiary Status

A patient's county of beneficiary status is to be determined in the same fashion as in Section II. B.-1 (i.e., using the POS device, contacting Social Security, contacting the Medi-Cal office, or by consulting DBH Financial Evaluation Section as a last resort). However, if a patient's county of beneficiary cannot be identified, Contractor is to provide San Bernardino County MHP with a completed 24-Hour Notification form and POS print-out, within 24-hours of admission.

TARs submitted to San Bernardino County MHP for reimbursement must be submitted within 14-days of discharge. Only those cases which involve San Bernardino County Medi-Cal eligible Individuals and Medically Indigent Adults and/or Children will be considered for approval.

5. Identity Unknown

If a patient's identity cannot be established, the local Sheriff's substation is to be contacted to have the patient's finger prints taken and examined. If a patient's identity cannot be determined, the San Bernardino County MHP Authorization Unit is to be contacted within twenty-four (24) hours of admission.

C. Medical Necessity

Medical necessity for inpatient psychiatric hospital care is defined by the presence of a mental condition manifested by acute symptoms of sufficient severity that the absence of immediate mental health services could reasonably be expected to result in a patient's health being placed in jeopardy, and/or the patient being a danger to self and/or to others, (i.e., services are needed to protect life or treat significant disability). Medical necessity never implies entitlement to a specific level of care, type of service, or specific service location. The appropriate service for an individual is always based on clinical judgment. Thus, the admission criteria listed herein do not entitle a person to receive Inpatient Services. It is the presence of an included diagnosis, a functional impairment, and documentation that the patient cannot be treated at a lower level of care that are required to meet admission criteria. Once it is determined the individual has a covered diagnosis, it is the severity of the functional impairment and evidence that the patient cannot be treated at a lower level of care that ultimately qualifies a service for reimbursement.

In order for acute services to be reimbursed, a patient must have been seen and evaluated by a psychiatrist and the patient's condition must meet ALL of the following criteria (i.e., 1 and 2).

1. Patient must have a valid DSM IV principal admitting diagnosis in one of the following categories:

   a. Pervasive Developmental Disorders

   b. Disruptive Behavior & Attention Deficit Disorder

   c. Feeding & Eating Disorder of Infancy or Early Childhood

d. Tic Disorders

e. Elimination Disorders

f. Other Disorders of Infancy, Childhood, or Adolescence

g. Cognitive Disorders, Dementias with delusions, hallucinations or depressed mood.

h. Substance Related Disorders, only with Psychotic, Mood, or Anxiety Disorder.

i. Mood Disorders

j. Anxiety Disorders

k. Somatoform Disorders

l. Dissociative Disorders (i.e., thought disorders)

m. Eating Disorders

n. Intermittent Explosive Disorder

o. Pyromania

p. Adjustment Disorders

q. Personality Disorders

r. Schizophrenia and Other Psychotic Disorders

2. Patient cannot be safely treated at another level of care, [i.e., lower levels of treatment have been attempted and have failed to remedy the patient's acute symptoms or reasons why less restrictive service resource(s) are inappropriate have been documented by the admitting or evaluating physician], and requires voluntary or involuntary admission due to the following (must have "a" or "b"):

a. Has symptoms or behaviors that meet one of 1), 2), or 3), below:

1) Presents a severe risk to physical health, is a current danger to self, or others, or is a threat to engage in significant property destruction as exemplified by the following: a recent suicide attempt, OR active suicidal threat(s) with a deadly plan, AND there is absence of appropriate supervision or structure to prevent suicide; a recent self-mutilative behavior (i.e., intentionally cutting or burning self) OR active threats of same with likelihood of acting on the threat, AND there is an absence of appropriate supervision or structure to prevent self-mutilation; an active hallucination(s) or delusion(s) directing or likely to lead to serious self-harm; recent serious assaultive behavior or sadistic behavior or active threat(s) of same with likelihood of acting on the threat(s), AND there is an absence of appropriate supervision or structure to prevent assaultive behavior.

2) Prevents the individual from providing for, or utilizing food, clothing, or shelter, as exemplified by the following: debilitating psychomotor agitation or retardation resulting in a significant inability to care for self; as a result of a mental disorder, is unable to provide for or utilize available resources to take care of basic personal needs, (i.e., food, clothing, or shelter); has been found mentally incompetent under Section 1370.01 of the Penal Code and the indictment or information pending against the defendant at the time of the commitment, charges the individual with a misdemeanor, and the indictment or information pending against the individual has not been dismissed, and as a result of a mental disorder, the person is unable to understand the nature and purpose of the proceedings taken against him and assist counsel in the conduct of his defense in a rational manner, and the individual is refusing medications that may reasonably allow him/her to reach a functional level sufficient to allow him/her to be tried for the original offense or be placed at a lower level of care.

[Note: An individual is not considered unable to provide for basic needs, even if (s)he meets the above criteria, if (s)he has responsible friends, family, or others who indicate their willingness (must be documented) to care for the individual

(with those held under PC 1370.01 excepted) and the individual is able and willing to take advantage of these resources. Services rendered to patients meeting this description will not be reimbursed.]

3) Represents a recent, significant deterioration in ability to function.

b. Requires admission for treatment and/or observation for [either 1), or 2) below]:

1) further psychiatric evaluation

2) medication treatment

3. The psychiatric condition must reflect the above criteria and be documented in the patient's chart.

D. Continued Stay

1. Criteria for a patient's hospital stay will be predicated upon documentation of one or more of the following criteria:

a. A patient meeting and continuing to meet the medical necessity criteria established on admission.

b. A patient's serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

c. The presence of new indicators which meet admission criteria described above.

d. Patient requires continuous medical evaluation/treatment that can only be provided if the patient remains in a 24-hour inpatient unit.

e. The treatment services provided meet standard of care for inpatient medical services as determined by MHP staff.

2. The provision of services must be reasonably expected to improve the patient's condition so that a lower level of care can be implemented following stabilization.

3. Contractor shall provide appropriate and timely discharge and aftercare planning for all admitted Medi-Cal eligible patients. The Contractor will identify a unit of qualified social workers/discharge planners who will consult with MHP staff to formulate and implement discharge plans and to link patients to appropriate aftercare placement resources. All discharge plans must be documented by the Contractor (i.e. any and all appropriate aftercare referrals).

4. Administrative Days

   a. Administrative days reimbursement will be awarded when the patient's stay must be continued beyond the patient's need for acute care due to the lack of residential placement options at appropriate, non-acute treatment facilities and the patient's stay previously met medical necessity criteria. (See Article I Definition of Terminology Paragraph C. of this Agreement; see also Attachment I regarding DBH Contracted facilities requiring referrals through DBH).

   b. To qualify for "Administrative Days" reimbursement for patients 18 years or older, Contractor will be responsible for contacting and documenting, at least once each five working days, all appropriate residential placement options (non-acute treatment facilities) within a sixty (60) mile radius until the patient is placed, or Medi-Cal reimbursement is no longer expected (i.e. patient no longer requires non-acute level of care).

   c. Documentation will be made in patient chart of contacts to non-acute treatment facilities each time a facility is contacted, with a brief description of the status, the name and location of the facility contacted and the signature of the person making the contact.

   d. Administrative Day Services is defined in Title 9, California Code of Regulations (CCR) Section 1701 as " Services authorized by a Mental Health Plan's Point of Authorization or a Short-Doyle /Medi-Cal provider's Utilization Review Committee that is acting as a Point of Authorization, for a beneficiary residing in a psychiatric inpatient hospital when, due to a lack of residential placement

options at appropriate, non-acute treatment facilities as identified by the Mental Health Plan, the beneficiary's stay at the psychiatric inpatient hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services." During the hospital stay, the beneficiary must also have met the medical necessity criteria for acute psychiatric inpatient hospital services.

The San Bernardino County Mental Health Plan has identified the following as Medi-Cal eligible non-acute treatment facilities that meet the Administrative Day Service criteria:

1) State Hospital;
2) Skilled Nursing facilities with a psychiatric component;
3) Institute for Mental Disease;
4) Licensed augmented board and care. These are designated board and care facilities that have a contract with DBH to provide specialized enhanced services to targeted populations. Non-augmented licensed board and care facilities do not qualify for administrative day reimbursement;
5) Shandin Hills Adolescent Center (SHAC);
6) RCL level 14-9 (Dept. of Behavioral Health Children's Residential System of Care (CRSOC) case manager should be involved to determine that the level of placement is clinically appropriate.)

Chart documentation requirements for administrative day service per the San Bernardino Mental Health Plan:

The lack of placement options at appropriate non-acute residential treatment facilities and the contacts made at appropriate facilities shall be documented to include but not be limited to, the following:

a) The status of the placement option. Document in the chart note the level, type and name of placement facility contacted and the disposition of each contact.
b) Date of the contact and name and title of the person contacted.

c) Signature and title of the person making the contact.

d) In cases where Contractor cannot make direct contact with potential facilities because there is a DBH case manager who functions as a placement gatekeeper, the Contractor is required to document the date of the placement referral and the type of referral and to whom the referral was made and to document the status of the placement referral weekly.

According to Title 9 requirements, the Contractor must document contacts with a minimum of five appropriate, non-acute treatment facilities per week. The DBH Point of Authorization staff may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary and there is sufficient documentation to support this. In no case shall there be less than one documented contact per week.

E. Quality Management

1. Contractor shall comply with requirements for utilization review pursuant to Title 42, CFR, Subpart D. Compliance shall include documentation of medical necessity, appropriateness of the level of care, and duration of services.

2. Contractor will establish a Utilization Review Committee (URC) whose function will be to determine that admissions and length of stay are appropriate to level of care and to ensure that MHP admission and continued stay criteria are met. Composition of the committee shall meet minimum federal requirements. A log shall be maintained, recording the date and outcome of each review, the patient's name, chart number, as well as the signature of the reviewer.

3. All Contractor Quality Management/Utilization Review records will be made available for review by MHP staff upon request.

4. Contractor's URC will take into account functioning level and utilization of other available resources when evaluating need for inpatient service upon admission and throughout the continued stay. Services which do not meet the minimum standards for medical necessity/least restrictive level of care are non-reimbursable.

5. MHP Authorization and Quality Improvement staff will be available to educate providers to ensure that federal URC requirements are met and that each provider's URC is familiar with the expectations of MHP in terms of quality and reimbursement issues. Contractor will be subject to MHP Quality Management Committee oversight. Quality care may be measured via performance outcome measures, other focused studies, audits, routine reviews, or other methods as determined necessary by MHP.

6. Quality of care provided to patients by the Contractor will meet MHP standard of inpatient care. Compliance will be assessed as part of the MHP payment authorization review process.

7. On-site Reviews

   MHP and the State Department of Mental Health shall conduct periodic audits, including on-site audits, of performance under this Agreement. These audits may include a review of the following:

   a. Level and quality of care, as well as the necessity and appropriateness of the services provided.

   b. Internal procedures for assuring efficiency, economy and quality of care.

   c. Compliance with MHP Patient Grievance Procedures.

   d. Financial records when determined necessary to protect public funds.

F. Authorization for Reimbursement

1. Contractor will notify MHP Authorization Unit of all admissions for which Medi-Cal reimbursement is expected within 24 hours of admission, via the "24-Hour Notification Form," and, to the extent feasible, provide MHP with identifying data and intake information as requested by MHP. **24-Hour Notifications are to be faxed to the MHP Authorization Unit at 909/387-7041.**

2. Contractor shall send proof of Medi-Cal eligibility for each 24-Hour Notification sent to the MHP Authorization Unit. If Medi-Cal eligibility has not been verified at the time of admission, and Medi-Cal is known to be pending, Contractor shall submit supporting documentation for pending Medi-Cal eligibility. This documentation may be provided by the client or may be available to Contractor through the State Medi-Cal system.

3. Reimbursement for services is contingent upon the Contractor meeting regulatory/licensing criteria.

4. Authorization for Reimbursement is the process utilized by MHP to ensure that patients receive the appropriate type and amount of services needed. Non-compliance with standards of inpatient care as determined by MHP will result in non-reimbursement of services. The absence of a daily progress note by a psychiatrist will result in nonpayment.

5. Contractor is responsible for providing authorized MHP representatives access to records and consistent face-to-face access to all Medi-Cal beneficiaries for whom the Contractor has submitted a 24-hour Notification for an inpatient admission. Denial of access will result in nonpayment to the Contractor. Nonpayment due to MHP staff being denied access to a patient where the MHP has received 24 Hour Notification is not appealable to the State.

6. Some planned admissions will be authorized with prior approval by MHP Authorization Unit staff. However, planned admissions are severely limited (e.g., for Electro Convulsant Treatment, some FDA approved medication trials, etc.)

7. Some services will be authorized/approved concurrently upon approval of MHP Authorization Unit staff.

8. Authorization for reimbursement will be an oversight review process. MHP staff will conduct case reviews retrospectively (in most cases) on an ongoing basis for the purpose of approval/denial of reimbursement. Reviews may include on-site, telephone review, review of Faxed documentation, or documentation sent to MHP via mail. The specific method(s) of review will be determined by MHP.

9. Contractor will be responsible for submission of Treatment Authorization Requests (TARs) to MHP on all cases in which Medi-Cal or Medically

Indigent Adult and/or Children reimbursement is required per Title 9 within 14 days of discharge. All TARs are to be sent to the following location within referenced timelines:

FOR SPECIAL DELIVERIES:

Department of Behavioral Health
ATTN: Authorization Unit
700 E. Gilbert Street, Building 2
San Bernardino, CA 92415-0920

FOR REGULAR MAIL:

Department of Behavioral Health
ATTN: Authorization Unit
P. O. Box 2610
San Bernardino, CA 92406-2610

10. Additional off-site or on-site review of records may be conducted periodically as part of MHP's Quality Management Committee oversight function.

11. A day of service shall be billed for each beneficiary who meets admission and/or continued stay criteria, documentation requirements, treatment and discharge planning requirements, and occupies a psychiatric inpatient hospital bed at 12:00 midnight in the contract facility. However, a day of service may be billed if the beneficiary is admitted and discharged during the same day, provided that such admission and discharge is not within 24 hours of a prior discharge.

12. The Contractor shall bear total risk for the cost of all psychiatric inpatient hospital services rendered to each Medi-Cal beneficiary covered by the Agreement.

13. Payment to the Contractor shall equal the negotiated rate per day, less any third party liability and shall not be subject to adjustments.

14. Under Fee-For-Service Acute Psychiatric Hospital Medi-Cal Consolidation, eligible Medi-Cal beneficiaries will receive inpatient mental health services consistent with standards set by the State and in accordance with Federal Medicaid requirements. The San Bernardino

County Department of Behavioral Health is the State-designated Local Mental Health Plan responsible for authorizing or denying Fee-For-Service Medi-Cal payment.

MHP clinicians, in accordance with the Federal (HCFA) Freedom of Choice waiver, relative to Section 1902(a)(23) of the Social Security Act, may initiate voluntary and/or involuntary transfer to alternative treatment sites as determined by MHP and in compliance with the Federal (HCFA) Freedom of Choice waiver granted to the State of California relative to Section 1902(a)(23) of the Social Security Act. Reimbursement will be denied for patients who refuse a voluntary transfer stipulated by MHP representatives as an alternative treatment source. The "MHP Transfer Form" provided to the FFS hospital will indicate the date beyond which payment will not be authorized.

Reimbursement for services rendered to patients prior to transfer stipulation will be determined by medical necessity via MHP payment authorization review process.

15. The Contractor will be responsible for providing authorized MHP representatives access to patients' records and consistent face-to-face access to all patients for whom the Contractor has submitted a 24-Hour Notification for an inpatient admission. Contractor will not be reimbursed for services rendered to patients who MHP staff have been prevented from interviewing. Nonpayment for denial of patient access is not appealable to the State. Reimbursement for services rendered to patients prior to MHP staff being denied an interview will be determined by medical necessity via MHP payment authorization review process.

III. Confidentiality Guidelines

A. Contractor will maintain all patient information and patients' records as part of one integrated service delivery system. The Contractor will release all information and records to MHP representatives as permitted or required by law. Information shall remain confidential as referenced in the W & I Code.

B. Contractor shall have a written procedure for release of information which shall be consistent with the requirements set forth in State and Federal laws and regulations.

C. Patient information and records shall be confidential and can only be released to agencies other than MHP with the patient's written permission, or as otherwise permitted by law. To the extent required by law, a signed patient release of information form will be used to authorize the exchange of patient information. The form will be specific in identifying the information that the agency requires.

IV. Quality of Care

A. Contractor will assure that all Medi-Cal beneficiaries receive care as specified in the Agreement.

B. Contractor shall provide psychiatric inpatient hospital services in the same manner to Medi-Cal beneficiaries as they are provided to all other patients.

C. Contractor shall not discriminate against Medi-Cal beneficiaries in any manner, including admission practices, placement in special wings or rooms, or the provision of special or separate meals.

D. Contractor shall provide the same standard of medical care as in the community, i.e. performing basic laboratory work upon admission, history and physical done within 24 hours of admission, blood levels of medications as indicated, e.g. tegretal, dilantin, depakote, etc.

E. When quality of care issues are identified by MHP staff, the issues will be referred to MHP Quality Improvement Working Committee and/or other Quality Management Committee/working group as appropriate, for review. MHP Quality Improvement Working Committee will review each referral and request a plan of correction, if indicated.

V. Complaint Resolution/Grievance Procedure

A. Contractor will be responsible for establishing an informal complaint resolution process and a formal grievance procedure to serve as a mechanism for resolution of patient complaints regarding any service related issues. The procedures must be outlined in the Contractor's Quality Management/UR Plan.

1. Informal Complaint Resolution Process

a. The informal complaint resolution process developed by Contractor will be patient friendly, easy to understand and will focus on quick, simple resolution of problems. Supervisory and

management staff, as well as patient advocates, may be utilized for the process. The focus of the informal complaint resolution will be expedient resolution of the complaint at the lowest staff /administrative level possible.

b. Upon admission, all patients will be advised verbally, and in writing of the procedure to be used for making a complaint. The complaint procedure will also be visibly posted in patient areas along with patient complaint forms. A hospital patient advocate, or other patient assistant, will be available to assist the patient upon his or her request.

c. The informal complaint resolution process may be initiated by the patient or someone else whom (s)he has designated to act on his/her behalf. To initiate the process, the patient or designee may register a verbal or written complaint with any Contractor staff member. That staff member will refer the complaint to the appropriate supervisor for resolution or referral, as outlined in the informal complaint resolution procedure of the County Implementation Plan for Psychiatric Inpatient Hospital Services Consolidation or Quality Management Plan. Any level of staff may be included in the process as required to resolve the complaint at the lowest staff level possible. All complaints and resolutions will be entered in a complaint log, and the patient will receive written feedback regarding the resolution of his/her complaint.

2. Formal Grievance Procedure

a. Should a service-related problem not be resolved at the informal level, the patient or his or her designee, may initiate a formal grievance procedure. The formal grievance procedure may be initiated at any time during the complaint/grievance process, should a patient request to pursue this right.

b. The formal grievance procedure is designed to allow the patient to follow a formal written procedure whereby (s)he may present his or her case fully and receive a written response from the Contractor and/or MHP.

c. All grievances will be recorded in the Contractor's grievance log immediately after the grievance is received. The request will then

be forwarded to the hearing officer, a psychiatrist (or designee), chosen on a rotational basis from a pool of psychiatrists appointed by the Director. The hearing officer may hear/review the case alone or with a panel of psychiatrists (or designees) from the existing pool.

d. The grievance will be resolved within 30 days and the results recorded in the log. If resolution is not possible within the designated time frame, an explanation will be recorded in the log.

e. The grievant and Contractor will be provided a written explanation of the resolution. If the grievant cannot be located, it will be noted in the log.

f. If the patient disagrees with the resolution of the grievance at the formal level, (s)he may appeal the findings to DBH Director of Medical Services. The Director, or designee, will review the grievance and provide the grievant and Contractor with a written explanation of his/her findings. The findings will be recorded in the Contractor's grievance log.

g. The DBH Director of Medical Services will be the final source of appeal for the patient. If the patient's grievance has not been resolved to his/her satisfaction and if the grievance involves reduction, termination, or denial of services, the patient may file a request for a State Fair Hearing (within the mandated time frames).

h. Patients shall not be subject to any manner of discrimination, penalty, sanction or restriction for filing complaints and/or exercising their grievance or appeal rights.

B. Contractor will provide patients with a full written description of the complaint resolution process and grievance procedure as well as the patient's right to go directly to the County's process at any time and the right to a State Fair Hearing when services are reduced, terminated, or denied.

C. Contractor will be responsible for designating staff or patient assistants to help patients with the complaint/grievance process if required or requested.

D. Patient satisfaction survey results are to be made available to MHP upon request. Information from the surveys may be periodically utilized by MHP to assess possible problem areas which may not have been registered as a patient complaint.

VI. Contractor Appeal Process

A. Should the Contractor have a concern regarding MHP denial of reimbursement for inpatient psychiatric hospital service, the MHP's written appeal procedures are to be followed. The Contractor has a right to access the Contractor Appeal Process at any time before, during, or after the Provider Problem Resolution Process has begun as set forth in the Medi-Cal Inpatient Provider Manual. The Contractor must submit a written appeal to MHP within 90 calendar days of the action precipitating the appeal, or the date of notification of a denied request for reimbursement. Nonpayment for MHP staff being denied access to a patient where the MHP has received 24 Hour Notification is not appealable to the State.

B. DBH Director of Medical Services, or designee, will review the case and provide, in writing, a decision to the Contractor within 60 calendar days from the receipt of the appeal and include a statement of the reasons for the decision that addresses each issue raised by the Contractor, and any action required by the Contractor to implement the decision. If the Contractor's appeal is upheld, MHP will submit an approved payment authorization within 30 days. If no basis is found for altering the original decision, or if the remedy is not within the purview of MHP, the Contractor will be notified of its right to submit an appeal to the State Department of Mental Health. If the DBH Director of Medical Services does not respond to the appeal within sixty days of receiving it, the appeal shall be considered approved. There is no second level of appeal in the Contractor Appeal Process within the MHP.

C. When quality of care issues are identified through the appeals process indicating possible access, clinical or system problems, as well as any patterns of concern, the issues will be referred to MHP Quality Improvement Working Committee for review. The MHP Quality Improvement Committee may request a plan of correction, with follow-up reports, if necessary, from Contractor.

VII. Outcome Evaluations

A. MHP will conduct ongoing assessments of outcomes achieved by the patients served by the Contractor. Outcomes include what the patient is able to achieve based on his stated goals and abilities with the help of services provided by the Contractor and/or MHP. Variables such as financial status, living arrangements, educational goals, functioning, social and support networks prior to, and/or during receipt of services may be examined. Symptom reduction and prevention of recidivism to higher levels of care may be used to measure outcomes.

B. The MHP will focus on a few important outcomes which are goals of the managed care system. Achievement of these goals will be monitored carefully to determine whether the program is functioning appropriately to allow achievement of these goals. The primary focus will be on concrete, measurable, and behavioral indications of functioning.

C. Assessment of outcomes is based upon comparisons with previous performance, with current established standards, with established practices and other available information. Intensive assessment followed by remedial action is warranted when undesirable variation in performances has been identified.

VIII. Patient Satisfaction

Patient satisfaction is a critical component measuring the quality of services provided by the Contractor. Periodically, patient satisfaction surveys will be distributed to patients by MHP to assess patient satisfaction with the services provided by the Contractor. The surveys are designed to accommodate language and cultural differences among patients and will be administered in the patient's primary language whenever possible. Survey questions will address the uniqueness of each age group (children, adolescents, adults, and older adults). Comments from the patient's family members and/or significant others, will also be taken into consideration. These surveys shall address various aspects of service delivery which includes access to service, waiting times, courtesy of staff and level of information provided concerning their illness. The patient satisfaction surveys will also be used as a measurement to determine future service planning and to ensure the services are developed to meet the needs and desires of the Contractor's patients.

IX. Miscellaneous Contractor Responsibilities

The Contractor shall:

A. Accept into an available and appropriately licensed bed, any Medi-Cal eligible patients referred to its facility who meet target inpatient medical necessity as outlined in this Addendum, Section II.

B. Transport patients to Contract hospital from non-contract hospital when feasible. When transportation services are Medi-Cal eligible, they shall be billed separately from the per diem rate for Psychiatric Inpatient Hospital Services. Costs associated with all other necessary transportation will be assumed by the Contractor under the negotiated per diem rate.

C. Evaluate, admit and treat patients who meet the documented need for inpatient hospitalization in compliance with MHP admission and continued stay criteria.

The Fee-for-Service and the Short-Doyle Medi-Cal Systems Admission Criteria are integrated under MHP and, as such, admission criteria at contract hospitals shall meet standards consistent with San Bernardino County MHP admission criteria. Designated 5150 treatment facilities shall be in compliance with the W & I Code regarding Involuntary Treatment. Contractor shall be in compliance with all other statutory and regulatory requirements. Findings of non-compliance and violations of patient's rights shall be forwarded by MHP representatives, and as appropriate, to the office of Patients' Rights.

D. Provide and document appropriate and timely discharge and aftercare planning.

E. Submit/FAX a daily written census to MHP for all Medi-Cal patients for whom the Contractor has submitted 24-Hour Notifications. **[FAX #909/388-4369]**

F. Provide appropriate office space for MHP staff to perform patient interviews and to review written documentation on patients at the facility. Contractor will facilitate MHP staff interviews of all patients for whom the Contractor has submitted 24-Hour Notifications for an inpatient stay. (See this , Section II.)

G. Assist patients requesting release in completing the standard Request for Release form (writ) for patients involuntarily detained (in hospitals with such capacity).

H. Maintain pharmacy in compliance with all appropriate regulations and laws.

I. Ensure that appropriate patients are recommended for temporary conservatorship in consultation/coordination with DBH Conservatorship Investigator's Office [at 909/421-9380] by making a needs assessment request.

J. Provide discharged patients with all psychiatric medication (up to 14 days) and necessary equipment that the facility has on hand prescribed for that patient or with a sufficient prescription to last the patient (up to 14 days) or until his/her first outpatient medication appointment, whichever is sooner.

K. Take appropriate steps to avoid readmission of patients to an acute level of psychiatric care by taking the following actions:

1. Refer all appropriate patients for community aftercare services.

2. Provide pertinent patient information to aftercare provider.

3. Ensure that crisis intervention services have been provided prior to patients being considered for admission to acute inpatient hospital.

Patterns of readmission may be referred to MHP Quality Assurance Committee. (Refer to Section IV. E.)

L. Contractor will be expected to develop an appropriately structured treatment program. Multi-disciplinary teams will be in place in each facility to ensure that quality psychiatric care is provided to patients. This includes medications (i.e., administration, education, documentation of side effects and attempts to ameliorate, etc.), individualized treatment plans, consultation with support systems (e.g. family members) and patient safety.

M. Consideration for special populations will be integrated into all aspects of the inpatient delivery system. The purpose of this is to assure equal access, equal treatment in the service delivery process, and consideration of special needs.

X. Miscellaneous MHP Responsibilities

MHP shall:

A. Provide information and consultation to Contractor to assist hospital staff to implement discharge and aftercare plans. These services will be provided upon request by Contractor and when deemed appropriate by MHP staff.

B. Educate Contractor as follows:

1. Provide Contractor with information regarding community placement resources available to adults and youth.

2. Provide Contractor with information regarding mental health community aftercare resources (i.e., Outpatient, Partial Hospitalization, Family Preservation, TEAM House, Wilderness Program, Home & Hospital Program, Intensive/Aggressive Case Management services, etc.).

C. Consult with Contractor:

1. On criteria for patients being referred for placement into a MHP residential resource system.

2. On referrals to alternatives for service in the community (i.e., Outpatient, Partial Hospitalization, Family Preservation, TEAM House, Wilderness Program, etc.).

3. On levels of care needed according to degree of impairment.

4. On current availability of community based residential system (e.g., group homes, Board and Care, Skilled Nursing Facilities, etc.).

D. Evaluate (upon referral from Contractor) for:

1. Adult (for admission to)

   a. State Hospital

   b. IMDs

   c. Augmented Board and Cares (ABC).

2. Youth (for admission to)

   a. State Hospital

   b. Mental Health Intensive/Subacute program.

c. Mental Health Transitional group home program.

d. Enriched Youth Home (Interagency/DCS).

E. Placement

1. When an individual is found to meet the appropriate criteria for any of the above placements, or is in need of case management (criteria to be supplied by DBH) a DBH referral/placement case manager is to be contacted by the Contractor (via the Managed Care Clinician) to coordinate placement arrangements and/or case management services, if appropriate as determined by MHP prior to discharge. Contractor shall not attempt to contact DBH contract residential providers directly to initiate placement.

2. Discharge coordination (related to X, E., 1) is to be accomplished via consultation (by telephone or face-to-face, depending upon the situation) between DBH Managed Care staff and Contractor staff. Contractor is to make appropriate staff available for these consultations.

3. Ongoing case management services for appropriate (as determined by MHP) select patients (criteria to be supplied by MHP) will be provided by MHP staff.

MHP CHILD/ADOLESCENT CONTRACTED FACILITIES

(Refer to Addendum I, Section II. D. 4. Continued Stay, Administrative Days)

Contractor is responsible for contacting the Hospital Aftercare Services (MHP Managed Care) Clinician to request referral to the following approved facilities:

Shandin Hills Adolescent Center – Mental Health Rehabilitation Center (MHRC)
Victor/Chapparel (Level 14)
East Valley Charlee (Level 11)
Metropolitan State Hospital

MHP ADULT CONTRACTED FACILITIES

(Refer to Addendum I, Section II. D. 4. Continued Stay, Administrative Days)

Contractor is responsible for contacting the Hospital Aftercare Services (MHP Managed Care) Clinician to request referral to the following approved facilities:

ASC Treatment Group, aka Anne Sippi Clinic
Beverly Manor
Linda Diann Spinks, Inc. dba Fontana Gardens
Linda Diann Spinks, Inc. dba Linda Villa Care
Metropolitan State Hospital
Mt. View Residential Board & Care
Orchid Court, Inc.
Orchid Court, Inc. d.b.a. Vanda Royale
Shandin Hills Behavioral Therapy
Braswell Enterprises, Inc. d.b.a. Sierra Vista
Vista Pacifica

DBH REIMBURSEMENT REQUIREMENTS

DBH will reimburse the Contractor for indigent care services provided by Contractor when the following conditions are met:

A. Patient is the subject of a 5150 application written by law enforcement or a DBH 5150-designated staff.

B. Upon contacting ARMC-BH, the law enforcement officer or Contractor's representative is notified by ARMC-BH staff that the facility is at or above capacity and "on diversion." The officer or representative shall document this information on the Diversion Verification Notice (see Attachment III).

C. Contractor shall make an attempt to transfer the patient to ARMC-BH within 24 hours of admission and shall document in the patient's record that transfer was refused by ARMC-BH as a result of being "on diversion" or as a result of inadequate bed capacity.

D. The patient is determined by Contractor to be a resident of San Bernardino County. Residency will be determined by a preponderance of the evidence, taking into consideration all of the following factors:

1. Reasoned Intention to reside or continue to reside in San Bernardino County. Reasoned Intention is based upon any of the following factors:
    a. Existence of a support system within San Bernardino County.
    b. Existence of new opportunities for the individual within San Bernardino County.
    c. History of having resided in San Bernardino County for at least three months.
2. Mental Health Services History as established by the locale where the most recent non-crisis, non-homeless related service was provided within the last two years.
3. Physical Dwelling: The existence of a physical dwelling, whether owned, rented or otherwise available to which the patient can return.
4. Public Benefits: A patient's receipt of public benefits (i.e., AFDC, General Assistance) received within San Bernardino County.

5. Probation or conditional release which restricts the patient to a particular locale within this county.
6. For purposes of this contract, LPS (private and public) and Probate Conservatees are considered to be residents of the county in which the conservatorship was established.

E. Additional factors for determining residency for minors:

1. For purposes of this contract, wards and dependents placed by the Juvenile Court are considered residents of the county of current court jurisdiction.
2. Special Education Pupils placed pursuant to an AB 2726 (formerly 3632) IEP are considered residents of the county (and school district) in which their parents or conservator reside until their 22nd birthday provided they remain in placement pursuant to a Special Education IEP.
3. For purposes of this contract, minors who are adopted through public agency adoptions remain the responsibility of the county making the adoptive placement.

F. The Contractor will perform an eligibility interview to determine eligibility for other benefits. Should the patient meet criteria for Medi-Cal or other benefits, the Contractor is to initiate an application for those benefits and may not seek Indigent Care Reimbursement from DBH.

G. Contractor's verification that a patient is not Medi-Cal eligible shall be provided by submission of the following documents:

1. Application for Reimbursement of Treatment To Medically Indigent Adult in Contract Hospital (see Attachment IV)

-or-

Application For Reimbursement of Treatment to Medically Indigent Child in Contract Hospital (see Attachment V).

2. Facility Application for Indigent Care Reimbursement (see Attachment VI).

-and-

3. Proof of denied Medi-Cal eligibility

H. Upon receipt of copy of patient's chart with the Contractor's invoice.

ATTACHMENT III

DIVERSION VERIFICATION

At the time and date indicated below, ARMC-BH was contacted by phone at which time confirmation was given that the facility was on diversion for <u>adults/children</u> at the time of contact. (circle one or both)

Re: (patient name) _____

Date of contact: _____

Time of contact: _____

Name of ARMC-BH staff member contacted: _____

Name of representative or law enforcement officer who made the contact:
_____

_____
Signature

APPLICATION FOR REIMBURSEMENT OF TREATMENT TO MEDICALLY INDIGENT ADULT IN CONTRACT HOSPITAL

Hospital _____ DBH Managed Care Unit Phone _____

Form Completed by: _____ Title _____ Phone _____

Client Name _____ DOB _____ SSN _____

PATIENT

☐ Male ☐ Female

_____
Last Name First M.I.

AGE: _____ DOB: _____ SSN: _____ ☐ Married ☐ Separated ☐ Single ☐ Divorced

Current Address:

_____ How Long? _____
Street Apt# City State Country

Previous Address:

_____
Street Apt# City State Country

Current Employer: _____ Job Title _____

Approximate Salary _____ per _____ Length of time employed in current position _____

Health Care Benefits (company) _____ Plan Name _____

Policy #_____ Does this policy include acute psychiatric inpatient benefits? ☐ YES ☐ NO

SPOUSE

_____
Last Name First Name M.I. DOB SSN

_____
Street Apt# City State Country

Current Employer: _____ Job Title _____

Approximate Salary _____ per _____ Length of time employed in current position _____

Health Care Benefits (company) _____ Plan Name _____

Policy #_____ Does this policy include acute psychiatric inpatient benefits? ☐ YES ☐ NO

CHILDREN (youngest to oldest):

_____
Last Name First Name M.I. DOB SSN

_____
Last Name First Name M.I. DOB SSN

_____
Last Name First Name M.I. DOB SSN

_____
Last Name First Name M.I. DOB SSN

	YES	NO
Are you pregnant?		
Are you over 65 years of age?		
Are you legally blind?		
Are you under 21 years of age?		
If "yes", are you married and living with your parent(s)?		
Are you in the United States as a refugee?		
Do you or your doctor expect your illness or injury to keep you from any kind of employment for more than 1 year?		
Do you have a child under 21 years of age in your home?		

If response to any question above is "yes", refer the person to a case worker for a state Medi-Cal application. If responses are all "no", refer the person for County Medical Services at the facility assigned to the zip code for the person's residence.

Do you currently have any medical condition (other than pregnancy) which has caused you to be unable to work for more than 30 days? If yes, please describe. ☐ YES ☐ NO
Please describe any medical condition which has caused you to be unable to work for more than one year:
Have you ever received SSA or SSI payments as a result of a mental disorder? ☐ YES ☐ NO If yes, please state the mental health diagnosis which qualified you for payments.
Do you currently suffer from a mental disorder that you believe is disabling? If yes, please describe.

I hereby declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____

Signature of Declarant Date

cc: DBH Fiscal

Routing: Original to Hospital
Submit to DBH, MCU
DBH Submit to TAD

APPLICATION FOR REIMBURSEMENT OF TREATMENT TO MEDICALLY INDIGENT CHILD IN CONTRACT HOSPITAL

Hospital _____ DBH Managed Care Unit Phone _____

Form Completed by: _____ Title _____ Phone _____

Client Name _____ DOB _____ SSN _____

PATIENT

☐ Male
☐ Female

_____
Last Name First M.I.

AGE: _____ DOB: _____ SSN: _____

Current Address:

_____ How Long? _____
Street Apt# City State Country

Previous Address:

_____
Street Apt# City State Country

MOTHER

_____
Last Name First Name M.I. DOB SSN

_____
Street Apt# City State Country

Current Employer: _____ Job Title _____

Approximate Salary _____ per _____ Length of time employed in current position _____

Health Care Benefits (company) _____ Plan Name _____

Policy # _____ Does this policy include acute psychiatric inpatient benefits? ☐ YES ☐ NO

Is this child's mother currently pregnant? ☐ YES ☐ NO
Does this child's mother currently have any medical condition (other than pregnancy) which has caused her to be unable to work for more than 30 days? If yes, please describe. ☐ YES ☐ NO
Please describe any medical condition which has caused her to be unable to work for more than one year:
Has this child's mother ever received SSA or SSI payments as a result of a mental disorder? ☐ YES ☐ NO If yes, please state the mental health diagnosis which qualified mother for payments.
Does mother currently suffer from a disabling mental disorder? If yes, please describe.

FATHER

Last Name | First Name | M.I. | DOB | SSN

Street | Apt# | City | State | Country

Current Employer: _____ Job Title _____

Approximate Salary _____ per _____ Length of time employed in current position _____

Health Care Benefits (company) _____ Plan Name _____

Policy # _____ Does this policy include acute psychiatric inpatient benefits? ☐ YES ☐ NO

Does this child's father currently have any medical condition which has caused him to be unable to work for more than 30 days? If yes, please describe. ☐ YES ☐ NO
Please describe any medical condition which has caused him to be unable to work for more than one year:
Has this child's father ever received SSA or SSI payments as a result of a mental disorder? ☐ YES ☐ NO If yes, please state the mental health diagnosis which qualified father for payments.
Does father currently suffer from a disabling mental disorder? If yes, please describe.

SIBLINGS (youngest to oldest):

Last Name | First Name | M.I. | DOB | SSN

Last Name | First Name | M.I. | DOB | SSN

Last Name | First Name | M.I. | DOB | SSN

Last Name | First Name | M.I. | DOB | SSN

I hereby declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Declarant | Date | Relationship to Child

cc: DBH Fiscal

Routing: Original to Hospital
Submit to DBH, MCU
DBH Submit to TAD

FACILITY APPLICATION FOR INDIGENT CARE REIMBURSEMENT

PATIENT DATA:

_____

Last Name First Name M.I. DOB SSN

Admitting Diagnosis:

Axis I
Axis II
Axis III
Axis IV
Axis V

To be completed by attending psychiatrist:

Please check any of the following that apply:

This patient suffers from a medical condition that would render him/her disabled from work for more than 30 days.
This patient suffers from a medical condition that would render him/her disabled from work for more than one year.
The mental disorder that led to this individual's admission is due to a pregnancy related or post-partum condition.

The above is stated on information and belief and I declare under penalty of perjury under the laws of the State of California that I believe it to be true.

_____

Attending Psychiatrist's Signature